Accessing community health services for malaria amongst conflict-affected communities in Cameroon: A qualitative study

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Introduction

- Cameroon is among the 29 countries that account for 96 percent of malaria infections globally.
- Malaria is the cause of over 40 percent of all deaths in Cameroon (WHO World Malaria report, 2021).
- 2011–2018: progress made in the reduction of malaria prevalence; household ownership of insecticide-treated nets increased.
- 2018: ongoing armed conflict in the Northwest (NW) and Southwest (SW) regions of Cameroon.
- August 2021: 375,000 internally displaced people (IDPs) and 443,000 returnees (OCHA, 2023), with movement between low and high prevalence areas.
- Overall, 29 percent of health services are non-functional (HNO, 2023).
- Poor access to health services due to insecurity and poor finances.

Objective

Overall study objective

- Develop, implement and evaluate scalable, replicable and innovative approaches to improve access to effective malaria case management, through community-based services in conflict-affected and host communities in the SW and Littoral regions of Cameroon.

Formative research: To explore the socio-cultural and health system context

- To understand challenges in accessing healthcare and malaria services by IDPs, factors for community health worker (CHW) use, and preference of key stakeholders for selected community engagement interventions for malaria prevention measures
- Combined with quantitative study – knowledge, attitude and practices (KAP) and malariometric surveys.

Mid-term review: To review progress on the implementation of the three interventions

- A community dialogue approach: Community Health Participatory Action (CoHPA)
- Monitoring of supportive supervision for CHWs
- Voucher system to support subsidised transport and treatment for simple and severe malaria.

Methodology

Methodology

Four conflict-affected health areas of the SW region and health areas in the Littoral region

SW region	Littoral
Ekondo-Titi	Manjo
Kumba	Mbanga
Muyuka	Nkongsamba
Tombel	

Formative — qualitative assessment

- 29 focus group discussions (FGDs) and 11 in-depth interviews (IDIs)
- Participatory consultations with key stakeholders and communities to identify and design contextualised innovations that would then be evaluated by the project
- Participant selection through convenience sampling in consultation with local leaders and CHWs to ensure a relevant IDP population
- FGDs led by a trained facilitator and a research assistant
- Data analysed thematically; open, descriptive coding combined with exploration of pre-determined investigative areas
- Analysis was conducted using the *Atlas Ti* version 9.0 software.

MTR process evaluation

- Fidelity implementation process, mediators reach participant responses for three interventions
- 10 FGDs and 17 IDIs
- Adapted methodology.

Results: Formative research

Reduced access to health services

Physical barriers to accessing care	**A lack of hospitals or health facilities, as many have closed or been destroyed or trusted health staff have left**
	Lack of transport links (affected by rainfall)
	Restrictions on movement due to fear of insecurity
	IDPs increased healthcare service demand but no additional resources
	Cost barriers: treatment/ referral

Results: Formative research

Community perceptions of community health workers	
NEGATIVES	**POSITIVES**
Low awareness	Close to home
Low CHW quality of care	Always available, willing to come night and day to help
CHW drug charges unaffordable	First-line treatment from CHWs is either free-of-charge or there are flexible payment options
Lack of trust (related to resourcing, language and security context)	Once capacity is proved, trust is built. The presence of a supervisor builds trust
Preference for hospital services	
Distribution is uneven; availability poor	

Results: Formative research

Community health worker experience	
NEGATIVES	**POSITIVES**
• Reduced CHW availability • Not given accommodation • Do not have own transport, clothing, tools, phones	Proud to serve their community
• Poor medical supply and drug availability	

Existing community engagement (CE)

CE approach	Community preference	Challenges
Village health committees (VHC)	• Prewar experience in all districts • Useful for awareness-raising, organising environmental management activities and discussing sanctions • A forum for everyone to participate, mobilise resources and enhance adherence to the decisions made • Gender balance in the committee is important.	• Committees require set-up • Tensions between committee members • Other organisations will take advantage • Challenging in conflict settings as they require financing • Language barriers will limit effectiveness.

Existing community engagement

CE approach	Community preference	Challenges
Community dialogue approach [(CDA) pr-Breaking Barriers, now implemented as COHPA]	• Prewar experience in Littoral • Will enable everyone to speak the most highly valued factor • People would feel invested.	• Ensure people participate and comply with decision taken.
Community scorecard (CSC)	• Only experienced in Kumba district • Considers everyone's views • Helps to identify individual weaknesses • Captures the thoughts of community members who do not like to speak up in other fora • Support prioritisation of problems • Improve the quality of services.	• May not serve visually impaired, language or literacy barriers.

Community dialogue + CSC selected

Factors that influence success of community meetings

NEGATIVES	POSITIVES
Engagement with the community leader prior to the introduction of new methods was important for an approach to be successful	Lack of participation from the community without incentives
CDA addresses the entire community CDA helps people to learn how to prevent diseases The community will be more open to giving their opinion CDA would give everyone the opportunity to be involved and would reflect the expectations of the community.	Weather constraints
	Power dynamics and disagreements
	Lack of a meeting venue
	Security disruptions
	Preferred use of non-local languages
	Provision of treatment would also be needed; education alone will not help.

MTR Results: Fidelity

Type of Intervention	Community activities	Challenges
CoHPA	• Planning is collective: CHW supervisors and community leader (CL) participation is not consistent; CHWs and CVs plan together. • Meetings are participatory and are delivered as planned to follow the manual and using the flipcharts provided • Action plans are followed • CSC system is followed and appreciated • CV selection process followed.	• Weaker in some locations • Limited by security as regular meetings are preferred • CSC can present bias • CV selection can be biased.
Supportive supervision	• Conducted monthly following guidelines.	• Quality varies by location. • Supervisors do not meet with CLs.
Vouchers	• Delivered as planned.	• One district received late and in short supply.

MTR Results: Implementation process

Type of Intervention	Community activities	Challenges
CoHPA	• Manuals and flipcharts easy to follow.	• Certain pictures required revision • Limited incentives, no incentives for planning activities • Materials needed for action plans • CVs need refresher training.
Supportive supervision		• Manuals not well distributed • Reporting tools are bulky to carry • Refresher training and supervisor training required • Incentives, rainwear and travel subsidies required.
Vouchers	• Needs-based calculation worked well.	• Challenges to understand reporting and eligible facilities.

MTR results: Mediators

Intervention	Community activities	Challenges
CoHPA	Confidence and comfort of CVs with materials and the CoHPA process improves with: • DCSO and CHW support and good relationships • Previous experience and prolonged experience with the programme • Supervision available time.	
Supportive supervision	• Communities know their CHW and understand their role • They rely on them for health education, testing, medication, follow-up for vaccination and ANC, support to access mosquito nets.	• Myuka: Women know CHWs' treatment role. Men are less aware and more likely to seek treatment elsewhere.
Vouchers		• The cost of drugs sold by CHWs impacts on voucher effectiveness • Vouchers impact on drug costs.

MTR results: Reach

Intervention	Activities	Challenges
CoHPA	• Only highly affected displaced remaining unreached • Men and women interact best when working in separate groups. People living with disabilities reached.	• Requires planning and investment • Any bias in the selection process affects reach • More work is needed to include blind; youth and older women are missed.
Supportive supervision	• Supervisors follow Ministry of Health systems.	• Challenges to reach every CHW by security, transport and competing work priorities.
Vouchers	• Key groups reached equally.	• Improved awareness required • Distance from CHWs affects decision to use services.

MTR results: Participant responses

Intervention	Responses
CoHPA	• Improved behaviours, sensing a change in mosquito biting levels, men are supporting ANC visits • Perceive and appreciate a formal position in malaria prevention • Women appreciate education and soap; men action plans • Incentives for planning, meetings and funding for action plans required.
Supportive supervision	• Supervision appreciated • Infrequent supervision, inadequate drugs • Incentives and training required • Improved reporting tools needed.
Vouchers	• Additional vouchers requested for older age groups, ANC and co-morbidities • Require increase in value for severe malaria • Increased sensitisation required • Vouchers in booklets to improve reporting.

MTR results: Additional participant responses

Context	• Insecurity and weather impacts on CoPHA: CHW supervision and service access • Location of displaced within the village and settlements • Long-lasting insecticidal net (LLIN) coverage: mixed response to availability • Drug availability.
Sustainability	CoHPA requires: • Training for stakeholders supporting CoHPA: community leaders and counsellors • Counsellors and district supervisor involvement • Increased financing • Supportive supervision requires increased technical support for supervisors and engagement at regional level • Inconsistent drug supplies are the major factor for trust and service utilisation.

Conclusions

Conclusion

- Community dialogue approaches are effective in this conflict setting to strengthen knowledge of mosquito net use and other prevention practices for malaria.
- Community dialogue approaches benefit from strong investment in community training and leadership.
- Community identified community training, funding for planning, dissemination and agreed action plans to strengthen the programme.
- Community health worker services are limited by conflict and affected by poor resourcing especially supervision and supplies. Supervision is valued but supervisors require increased training, improved supply systems and improved reporting systems.
- Cash assistance is only effective within a continuum of care with assured functioning health facilities and may not benefit the hardest to reach.

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